Friends of the Health Resources and Services Administration (HRSA)
c/o American Public Health Association
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Testimony of the Friends of the Health Resources and Services Administration (HRSA)

Concerning the Health Resources and Services Administration Budget for Fiscal Year 2007

Submitted to the House Appropriations Subcommittee on Labor, Health and Human Services and Education

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March 27, 2006
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Representing the Friends of the Health Resources and Services Administration (HRSA)

Summary:

Through its programs in thousands of communities across the country, HRSA provides a health safety net for medically underserved individuals and families, including 45 million Americans who lack health insurance; 49 million Americans who live in neighborhoods where primary health care services are scarce; African American infants, whose infant mortality rate is more than double that of whites; and the estimated 850,000 to 950,000 people living with HIV/AIDS. Programs to support the underserved place HRSA on the front lines in responding to our nation's racial/ethnic and rural/urban disparities in health status. HRSA funding goes where the need exists, in communities all over America. We support a growing trend in HRSA programs to increase flexibility of service delivery at the local level, necessary to tailor programs to the unique needs of America's many varied communities. The agency's overriding goal is to achieve 100 percent access to health care, with zero disparities. **In the best professional judgment of the members of the Friends of HRSA, to respond to this challenge, the agency will require an overall funding level of at least $7.5 billion for fiscal year 2007.**

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The Friends of the Health Resources and Services Administration (HRSA) is an advocacy coalition of more than 100 national organizations, collectively representing millions of public health and health care professionals, academicians and consumers. Our member organizations strongly support the programs at HRSA designed to ensure Americans' access to health services.

Through its programs in thousands of communities across the country, HRSA provides a health safety net for medically underserved individuals and families, including 45 million Americans who lack health insurance; 49 million Americans who live in neighborhoods where primary health care services are scarce; African American infants, whose infant mortality rate is more than double that of whites; and the estimated 850,000 to 950,000 people living with HIV/AIDS. Programs to support the underserved place HRSA on the front lines in responding to our nation's racial/ethnic and rural/urban disparities in health status. HRSA funding goes where the need exists, in communities all over America. We support a growing trend in HRSA programs to increase flexibility of service delivery at the local level, necessary to tailor programs to the unique needs of America's many varied communities. The agency's overriding goal is to achieve 100 percent access to health care, with zero disparities. **In the best professional judgment of the members of the Friends of HRSA, to respond to this challenge, the agency will require an overall funding level of at least $7.5 billion for fiscal year 2007.**

The Friends of HRSA are gravely concerned about the president's budget recommendation of a $255 million overall cut for fiscal year 2007, including over 12 program eliminations. This is in addition to the 12 programs that were eliminated in the fiscal year 2006 appropriations bill and other programs that received deep cuts in both years.

Through its many programs and new initiatives, HRSA helps countless individuals live healthier, more productive lives. In the 21st century, rapid advances in research and technology promise unparalleled change in the nation's health care delivery system. HRSA could be well positioned to meet these new challenges as it continues to provide needed health care to the nation's most vulnerable citizens.

The Primary Care Bureau received a $181 million increase, all of which is designated for the Community Health Centers. Community-based health centers and National Health Service Corps-supported clinics form the backbone of the nation's safety net. More than 4,000 of these sites across the nation provide needed primary and preventive care to nearly 13 million poor and near-poor Americans. HRSA primary care centers include community health centers, migrant health centers, health care for the homeless programs, public housing primary care programs and school-based health centers. Health centers provide access to high-quality, family-oriented, culturally and linguistically competent primary care and preventive services, including mental and behavioral health, dental and support services. Nearly three-fourths of health center patients are uninsured or

on Medicaid, approximately two-thirds are people of color, and more than 85 percent live below 200 percent of the poverty level. Additional primary care is provided by 2,700 clinicians in the National Health Service Corps. Corps members work in communities with a shortage of health professionals in exchange for scholarships and loan repayments.

The Bureau of Health Professions received $342 million in cuts in FY 2007 budget which is 46% of its budget. Health professions and nursing education programs, authorized under Titles VII and VIII of the Public Health Service Act, are essential components of American's health care safety net, bringing health care services to our underserved communities. An adequate, diverse, well-distributed and culturally competent health workforce is indispensable to our national readiness efforts. The health professions programs support the training and education of health care providers with the aim of enhancing the supply, diversity, and distribution of the workforce, filling the gaps in the health professions' supply not met by traditional market forces. Through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and non-profit organizations, the Title VII and VIII health professions programs are the only federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the health care workforce. We are concerned that cuts to Title VII health professions programs will exacerbate existing provider shortages in rural, medically underserved, and federally designated health professions shortage areas. While we applaud the $181 million increase in the President's budget for Community Health Centers, these cuts to the Health Professions raise the question of whether there will be a sufficient number of health care providers to staff these clinics. These programs provide up-front incentives for dozens of types of health professionals—not only physicians, but mental health, public health and dental providers as well—encouraging them to pursue health careers in areas that would otherwise go unserved. Cuts will also impede recruitment of underrepresented minorities and students of disadvantaged backgrounds into the health professions. This action will have the further consequence of intensifying already problematic health disparities. We are also concerned about the impact health professions cuts will have on vulnerable populations such as the elderly. Adequate funding for HRSA Health Professions Programs under Title VII and VIII will help to create a prepared national workforce by reversing projected nationwide shortages of nurses, pharmacists, and other professionals. In addition to the dismay we have aboutthe Health Professions programs that were eliminated this year, we are deeply concerned about the program cuts and eliminations proposed in the Title VII and VIII programs in fiscal year 2007. We strongly encourage the Subcommittee to restore cuts to these vital Health Professions programs.

The Maternal and Child Health Bureau was cut by $36 million to $780 million. Valuable programs like the Traumatic Brain Injury program, Universal Newborn Hearing Screening, and Emergency Medical Services for Children were zeroed out and the Maternal and Child Health Block Grant was level funded. The Maternal and Child Health Block Grant is a source of flexible funding for states and territories to address their unique needs, and remains in great need of increased funding. The Title V Maternal and Child Health Block (MCH) Grant received a $31 million cut in the fiscal year 2006 budget. The president's budget for fiscal year 2007 proposed level funding for the block grant at the FY06 level. Operating for a second year with less funds than in FY05, and greater needs among more pregnant women, infants, and children, particularly those with special health care needs presents daunting challenges to the state maternal and child health programs. Furthermore, if programs like the Traumatic Brain Injury program, Universal Newborn Hearing Screening, and Emergency Medical Services for Children program are eliminated, those costs will be borne by the MCH Block Grant. Each year, a MCH program serves more than 26 million pregnant women,

infants and children nationwide. Of the nearly 4 million mothers who give birth annually, almost half receive some prenatal or postnatal service from a MCH-funded program. MCH programs increase immunizations and newborn screening, reduce infant mortality and developmentally handicapping conditions, prevent childhood accidents and injuries, and reduce adolescent pregnancy.

Nationally there are 1.4 million brain injuries per year, with an estimated societal cost of over $60 billion per year, including direct care and lost productivity. Research indicates that 50,000 individuals die as a result of Traumatic Brain Injury (TBI) each year in the United States and an additional 80,000 survive with residual long-term impairments. Today over 5.3 million Americans are living with a TBI-related disability. TBI can strike at anyone at any time—from falls, vehicle crashes, sports injuries, violence, and other causes. HRSA's Traumatic Brain Injury program makes grants to states to coordinate, expand and enhance service delivery systems in order to improve access to services and support for persons with TBI and their families. Despite increasing numbers of soldiers returning from war with head injuries, increasing numbers of children being identified as disabled due to head injuries, and the release of an Institute of Medicine Report stating the importance of the program to brain injury survivors and their families, the Administration's fiscal year 2007 budget eliminates the TBI State Grant program. We encourage the Subcommittee to restore cuts to the TBI State Grant program. Furthermore, individuals with traumatic brain injury have an array of protection and advocacy needs, including assistance with returning to work; finding a place to live; accessing needed supports and services, such as attendant care and assistive technology; and obtaining appropriate mental health, substance abuse, and rehabilitation services. Very often, these individuals are the victims of stigma and discrimination because so little is understood about the effects of TBI. In addition, many people with TBI – including returning veterans – are forced to remain in extremely expensive institutional settings far longer than necessary because community-based supports and services they need are not available. We encourage the Subcommittee to restore funding for the Protection and Advocacy for Traumatic Brain Injury Program.

The Children's Health Act of 2000 authorized funding for grants and programs to improve state-based newborn screening. Newborn screening is a public health activity used for early identification of infants affected by certain genetic, metabolic, hormonal or functional conditions for which there is effective treatment or intervention. Screening detects disorders in newborns that, left untreated, can cause death, disability, mental retardation and other serious illnesses. Parents are often unaware that while nearly all babies born in the United States undergo newborn screening tests for genetic birth defects, the number and quality of these tests vary from state to state. Screening programs coordinated through the HRSA Bureau of Maternal and Child health help to ensure that every baby born in the United States receives, at a minimum, a universal core group of screening tests regardless of the state in which he or she is born. However, the Administration again proposes eliminating the universal newborn hearing screening program. It goes without saying that more disorders will go unnoticed if the affected newborns are not screened. We encourage the Subcommittee to restore funding for the newborn hearing screening program.

The proposed elimination of the Emergency Medical Services for Children (EMSC) Program is also concerning to us, especially considering the many children who are eligible for Medicaid and SCHIP but who cannot enroll due to enrollment limits and budgetary pressures. The Emergency Medical Services for Children Program, administered by HRSA, is a national initiative designed to reduce child and youth disability and death due to severe illness and injury. The federal funds that are contributed to this program are supplemented by funding from private sources, including parents

and volunteers. HRSA administers the program in partnership with the U.S. Department of Transportation's National Highway Traffic Safety Administration. EMSC grants fund States and U.S. Territories to improve existing emergency medical services (EMS) systems and to develop and evaluate improved procedures and protocols for treating children. Children are not merely small adults. They have very unique and specific concerns that this programs works to address. We request that the $20 million funding level be restored.

The Healthcare Systems Bureau received a cut of $13 million to $536 million. We are concerned with the funding level in the hospital preparedness program. Although the Administration proposes level funding, we are concerned with the $13 million cut the program took in fiscal year 2006. In the post 9/11 era, all responders, providers and facilities must be ready to detect and respond to complex disasters, including terrorism, and HRSA must continue to support these vital hospital preparedness programs.

Furthermore, HRSA's Trauma-EMS Systems Program was eliminated in the fiscal year 2006 appropriations bill. This program facilitates the development of effective and comprehensive statewide trauma systems. This program is critical in order to ensure that our response to local, state and federal emergencies is effective and reflects the best clinical practice in trauma and emergency medicine. We request that the $3.5 million funding level be restored.

The Office of Rural Health Policy was cut by 83% in the President's budget. HRSA programs improve health care service for the more than 61 million people who live in rural America. Although almost a quarter of the population lives in rural areas, only an eighth of our doctors work there. Because rural families generally earn less than urban families, many health problems associated with poverty are more serious, including high rates of chronic disease and infant mortality. We encourage the Subcommittee to restore funding for rural health programs.

An estimated 163,221 Americans experience out-of-hospital sudden cardiac arrests each year. Only an estimated 6 percent of them survive. Immediate CPR and early defibrillation using an automated external defibrillator (AED) can more than double a victim's chance of survival. For every minute that passes without CPR and defibrillation, the chances of survival decrease by 7 to 10 percent. The HRSA Rural and Community Access to Emergency Devices Program provides grants to states to train lay rescuers and first responders to use AEDs and purchase and place these devices in public areas where cardiac arrests are likely to occur. We encourage the Subcommittee to restore funding for this program to the fiscal year 2005 level of $8.927 million.

The HIV/AIDS Bureau received a $95 million increase. The Ryan White CARE Act programs, administered by HRSA's HIV/AIDS Bureau, are the largest single source of federal discretionary funding for HIV/AIDS health care for low-income, uninsured and underinsured Americans. Although we are pleased with the additional funds for comprehensive care and early intervention, we are concerned that previous years cuts has diminished the reach of the Ryan White CARE Act has been diminishedSince fiscal year 2003, funding to the most impacted cities has been cut by $15 million and funding to the states has been cut by $8 million. These cuts have forced state and local HIV/AIDS programs to stretch already thin CARE Act dollars to treat existing clients while trying to provide care and treatment to those newly diagnosed as HIV-positive. We request an increase of $577 million for CARE Act programs in fiscal year 2007.

In fiscal year 2006 the AIDS Drug Assistance Programs (ADAP) received a $2 million increase. Unfortunately, this program, which provides life-sustaining treatment to thousands of people living with HIV/AIDS, cannot be sustained on such an increase. By the end of fiscal year 2006 it is expected that hundreds more individuals will be added to ADAP waiting lists and that states will have had to institute other cost-containment measures such as reduced formularies, increased cost-sharing for ADAP clients and lowered eligibility requirements for enrollment. We request an increase of $197 million for the ADAP program.

Title X of the Public Health Service Act was enacted to provide high-quality, subsidized contraceptive care to those who need but cannot afford such services, to improve women's health, reduce unintended pregnancies, and decrease infant mortality and morbidity. Title X programs provide comprehensive, voluntary and affordable family planning services to millions of low-income women and men—many of whom are uninsured—at more than 4,600 clinics nationwide. People who visit Title X funded clinics receive a broad package of preventive health services, including breast and cervical cancer screening, blood pressure checks, anemia testing, and STD/HIV screening.

A major source of HRSA's strength is its many linkages and partnerships with other federal agencies, state, national and local organizations. For example, HRSA and the Centers for Medicare and Medicaid Services (CMS) are jointly implementing outreach on the new State Children's Health Insurance Program in addition to working together to improve data sharing and coordination, particularly on Medicaid. Work also is ongoing with the Substance Abuse and Mental Health Services Administration (SAMHSA) to integrate behavioral health and substance abuse screening, early intervention, referral and follow-up into primary health care settings funded through HRSA grants. HRSA and the Centers for Disease Control and Prevention (CDC) cooperate on a variety of disease prevention and health promotion activities.

Cross-cutting HRSA programs continually respond to new public health challenges. For instance, tooth decay remains the single most chronic childhood disease in the nation. However, about 125 million Americans have no dental insurance. Lack of access to dental care is especially severe among children of poor, rural and minority families. A quarter of the nation's school-age children have 80 percent of all dental disease, putting them at risk for a host of related illnesses. And as new drugs help people with HIV/AIDS live longer, healthier lives, their need for regular oral health care will continue to increase. HRSA can help both groups by increasing the number of dentists in community and school-based centers and by providing greater reimbursements to hospital dental clinics and dental schools for the growing costs of treating people living with HIV/AIDS.

Among the programs that were eliminated in the fiscal year 2006 appropriations bill are Healthy Community Access Program and the State Planning Grants program. Each of these programs helps communities and states provide access to health care for those who need it most. We encourage the Subcommittee to restore funding to these and other programs eliminated in the fiscal year 2006 appropriations bill.

We urge the members of the Subcommittee to restore the cuts and fund the agency at a level that allows HRSA to effectively implement these important programs. The members of the Friends of HRSA are grateful for this opportunity to present our views to the Subcommittee.

Biography for

Georges C. Benjamin, MD, FACP

Executive Director

American Public Health Association

Georges C. Benjamin, MD, FACP, is well known in the world of public health as a leader, practitioner and administrator. Benjamin has been the executive director of the American Public Health Association (APHA), the nation's oldest and largest organization of public health professionals, since December 2002. He came to that post from his position as secretary of the Maryland Department of Health and Mental Hygiene, where he played a key role developing Maryland's bioterrorism plan. Benjamin became secretary of the Maryland health department in April 1999, following four years as its deputy secretary for public health services.

Benjamin, of Gaithersburg, Md., is a graduate of the Illinois Institute of Technology and the University of Illinois College of Medicine. He is board-certified in internal medicine and is a fellow of the American College of Physicians.

An established administrator, author and orator, Benjamin started his medical career in 1981 in Tacoma, Washington, where he managed a 72,000-patient visit ambulatory care service as chief of the Acute Illness Clinic at the Madigan Army Medical Center. A few years later, he moved to Washington, D.C., where he served as chief of emergency medicine at the Walter Reed Army Medical Center. After leaving the Army, he chaired the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital. He was promoted to Acting Commissioner for Public Health for the District of Columbia and later directed one of the busiest ambulance services in the nation as interim director of the Emergency Ambulatory Bureau of the District of Columbia Fire Department. Prior to joining APHA, he was the chief executive of the state of Maryland's Department of Health and Mental Hygiene, a cabinet level agency.

At APHA, Benjamin also serves as the publisher of the nonprofit's monthly publication, The Nation's Health, the association's official newspaper and The American Journal of Public Health, the professions premier scientific publication. He is the author of over 80 scientific articles and book chapters.

Benjamin is a member of several committees, including the U.S. Centers for Disease Control and Prevention director's advisory committee. He also serves on the boards of Research America, Partnership for Prevention and Advocates for Highway and Auto Safety. He is a member of the Institute of Medicine of the National Academies of Science.

Disclosure of the amount and source of each federal grant received by the American Public Health Association

DHHS (Obesity & Diabetes)	$10,000	Sep-03
Center for Disease Control (EMS/Public Health)	$50,009	Aug-04
Nat'l Inst. Of Environmental Health Sciences	$18,000	Aug-04
CDC (PHP Disabilities)	$330,000	Dec-04
CDC (Environmental Health Competency)	$90,000	2003
DHHS (Pub. Hlth. Conference Student Conference)	$20,000	Sep-03
Nat'l Highway Traffic Safety Administration	$250,000	Aug-05